

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

8140

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Tow Primary Registration District No. 1000 Registered No. _____
 City Jackson City (No. Christian Church Hospital) St. _____ Ward _____

2. FULL NAME

Mrs. Belle May Wells
 (a) Residence. No. 4411 Scarrill St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 12 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

6a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Edwin James Wells

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 1 - 1864

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
61 | 9 | 1 | _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Home
 (b) General nature of industry, business, or establishment in which employed (or employer) mother
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Knoxville Iowa

10. NAME OF FATHER David Simmons

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ill

12. MAIDEN NAME OF MOTHER Mary Catherine Cromwell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ill

14. INFORMANT Mr Edwin J. Wells (Address) 51 4411 Scarrill

15. FILED 3/2 26 M. M. Lawrence REGISTRAR 1926

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 2 1926

17. I HEREBY CERTIFY That I attended deceased from Jan 15, 1926 to Mar 2, 1926 that I last saw her alive on Mar 2, 1926 and that death occurred, on the date stated above, at S.A.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cholelithiasis

12-3 (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) Acute nephritis (uraemia) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH. _____

DID AN OPERATION PRECEDE DEATH. yes DATE OF Feb 9 1926

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. B. Jones M.D.
1019 Ogden St. Wells

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill Cemetery DATE OF BURIAL 3-3 1926

20. UNDERTAKER Clyde Bros ADDRESS 1860 Linwood

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles*, *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Dr. Austin B. Jones
1019 Ave. of the Arts
2340 Jackson Ave. Chicago, Ill. 5390

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1. PLACE OF DEATH
 County Jackson Registration District No. _____ File No. _____
 Township Raw Primary Registration District No. _____ Registered No. _____
 City Kansas City (No. Christian Church Hospital St. _____ Ward) _____

2. FULL NAME Mrs. Rilla May Wells
 (a) Residence No. 4411 Scarriet St., _____ Ward. _____
 (Usual place of abode) _____ (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Edwin James Wells

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 1 - 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
61 9 1

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Home
 (b) General nature of industry, business, or establishment in which employed (or employer) mother
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Knottville Iowa
 (STATE OR COUNTRY) _____

10. NAME OF FATHER David Simmons

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ill
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Mary Catherine Cromwell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ill
 (STATE OR COUNTRY) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 2 1926

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, 19____, m.
 THE CAUSE OF DEATH WAS AS FOLLOWS:
thrombolithrosis
acute nephritis
 (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY uraemia 5 days
 (SECONDARY) (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) Austin B. Jones, M. D.
 , 19____ (Address) 1019 Argyle Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

14. INFORMANT Edwin James Wells
 (Address) 4411 Scarriet

15. FILED _____, 19____ REGISTERAR _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill Cemetery DATE OF BURIAL 3-3 1926

20. UNDERTAKER Eyles Bros ADDRESS 1800 Linwood

SUPPLEMENT

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S COUPON should state name of patient, may be properly classified. All a member of OCCUPATION in very important.

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"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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